		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Drive (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618) 233-7750 **Fax #** (618) 2576839

IDPA ID Number: 37-0635502-002

Date of Initial License for Current Owners: 03/01/64

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Eleanor Benton **Telephone Number:** (618) 257-5603

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 04/22/04 (Date)
(Type or Print Name) Mary Ann Hagler
(Title) Administrative Assistant & Director of Nursing

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,112		22,934	27,046	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,112		22,934	27,046	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.61%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/03/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 108 and days of care provided 9,732

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	414,772	2,400		417,172		417,172	242,169	659,341			1
2	Food Purchase		301,022		301,022		301,022		301,022			2
3	Housekeeping	110,156	10,855		121,011		121,011	48,256	169,267			3
4	Laundry		82,152		82,152		82,152	45,182	127,334			4
5	Heat and Other Utilities			75,086	75,086	(2,284)	72,802		72,802			5
6	Maintenance	64,271	14,968		79,239		79,239	14,242	93,481			6
7	Other (specify):*											7
8	**TOTAL General Services**	589,199	411,397	75,086	1,075,682	(2,284)	1,073,398	349,849	1,423,247			8
	B. Health Care and Programs											
9	Medical Director					13,272	13,272		13,272			9
10	Nursing and Medical Records	2,328,364	149,223	15,640	2,493,227	18	2,493,245	60,730	2,553,975			10
10a	Therapy	472,886	21,844		494,730		494,730	170,089	664,819			10a
11	Activities	75,184	2,980		78,164		78,164		78,164			11
12	Social Services	59,958			59,958		59,958	59,910	119,868			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Disposable Diapers**		77,940		77,940	(12,932)	65,008	(27,075)	37,933			15
16	**TOTAL Health Care and Programs**	2,936,392	251,987	15,640	3,204,019	358	3,204,377	263,654	3,468,031			16
	C. General Administration											
17	Administrative	82,196			82,196	(13,272)	68,924		68,924			17
18	Directors Fees											18
19	Professional Services			4,100	4,100		4,100		4,100			19
20	Dues, Fees, Subscriptions & Promotions			5,704	5,704		5,704		5,704			20
21	Clerical & General Office Expenses	49,537		12,437	61,974	775	62,749	143,416	206,165			21
22	Employee Benefits & Payroll Taxes			662,402	662,402		662,402	120,034	782,436			22
23	Inservice Training & Education											23
24	Travel and Seminar			982	982		982		982			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,798	48,798		48,798		48,798			26
27	Other (specify):* **Bad Debts**			58,906	58,906		58,906	(58,906)				27
28	**TOTAL General Administration**	131,733		793,329	925,062	(12,497)	912,565	204,544	1,117,109			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,657,324	663,384	884,055	5,204,763	(14,423)	5,190,340	818,047	6,008,387			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Memorial Convalescent Center #0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			138,406	138,406		138,406	95,951	234,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					12,932	12,932		12,932			35
36	Other (specify):*											36
37	**TOTAL Ownership**			138,406	138,406	12,932	151,338	95,951	247,289			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	76,083	293,652		369,735		369,735	32,426	402,161			39
40	Barber and Beauty Shops					1,491	1,491		1,491			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*	56,327	45,129	10,436	111,892		111,892	55,003	166,895			43
44	**TOTAL Special Cost Centers**	132,410	338,781	69,566	540,757	1,491	542,248	87,429	629,677			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,789,734	1,002,165	1,092,027	5,883,926		5,883,926	1,001,427	6,885,353			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,853)	30		9
10	Interest and Other Investment Income	(44)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,906)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,803)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,070,230		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,070,230		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,001,427		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x	1,491	40	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,491		47

STATE OF ILLINOIS

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	242,169	0	0	0	0	0	0	0	0	0	242,169	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	48,256	0	0	0	0	0	0	0	0	0	48,256	3
4	Laundry	0	45,182	0	0	0	0	0	0	0	0	0	45,182	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	14,242	0	0	0	0	0	0	0	0	0	14,242	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	349,849	0	0	0	0	0	0	0	0	0	349,849	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	60,730	0	0	0	0	0	0	0	0	0	60,730	10
10a	Therapy	0	170,089	0	0	0	0	0	0	0	0	0	170,089	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	59,910	0	0	0	0	0	0	0	0	0	59,910	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(27,075)	0	0	0	0	0	0	0	0	0	(27,075)	15
16	**TOTAL Health Care and Programs**	0	263,654	0	0	0	0	0	0	0	0	0	263,654	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(44)	143,460	0	0	0	0	0	0	0	0	0	143,416	21
22	Employee Benefits & Payroll Taxes	0	120,034	0	0	0	0	0	0	0	0	0	120,034	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,906)	0	0	0	0	0	0	0	0	0	0	(58,906)	27
28	**TOTAL General Administration**	(58,950)	263,494	0	0	0	0	0	0	0	0	0	204,544	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(58,950)	876,997	0	0	0	0	0	0	0	0	0	818,047	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Convalescent Center # 0003103 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,853)	105,804	0	0	0	0	0	0	0	0	0	95,951	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,853)	105,804	0	0	0	0	0	0	0	0	0	95,951	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	32,426	0	0	0	0	0	0	0	0	0	32,426	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	55,003	0	0	0	0	0	0	0	0	0	55,003	43
44	**TOTAL Special Cost Centers**	0	87,429	0	0	0	0	0	0	0	0	0	87,429	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(68,803)	1,070,230	0	0	0	0	0	0	0	0	0	1,001,427	45

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Employee Benefits	$ 662,402	Memorial Hospital	0.00%	$ 782,436	$ 120,034	1
2	V	21	Administration	62,749			206,209	143,460	2
3	V	6	Maintenance	79,239			93,481	14,242	3
4	V	4	Laundry	82,152			127,334	45,182	4
5	V	3	Housekeeping	121,011			169,267	48,256	5
6	V	1	Dietary	417,172			659,341	242,169	6
7	V	15	Central	65,008			37,933	(27,075)	7
8	V	39	Pharmacy,Medical Supplies	369,735			402,161	32,426	8
9	V	43	Ancillary services	111,892			166,895	55,003	9
10	V	12	Social Service	59,958			119,868	59,910	10
11	V	10	Medical Records	1,509			62,239	60,730	11
12	V	10a	Therapy	494,730			664,819	170,089	12
13	V	30	Depreciation	138,406			244,210	105,804	13
14	Total			$ 2,665,963			$ 3,736,193	$ * 1,070,230	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Emp Ben-Nursing & Med Dir	Salaries	68,792,936	2	$ 21,984,846	$ 599,175	2,303,034	$ 736,004	1
2	21	Patient Accounts	Revenue	331,922,606	2	2,599,208	1,088,798	3,954,372	30,966	2
3	21	Communications	Phones	1,092	2	488,598	187,758	6	2,685	3
4	21	Data Processing	Resources	10,001	2	1,986,619	733,747	72	14,302	4
5	21	Materials Management	Stores Requisitions	5,420,359	2	765,823	437,294	100,208	14,158	5
6	21	Administration	Accumulated Cost	140,402,986	2	11,065,629	3,541,365	3,458,887	272,606	6
7	6	Plant	Square Feet)	18,453	2	190,361	64,271	16,119	166,283	7
8	4	Laundry	Pounds	2,419,080	2	935,500	349,897	329,268	127,334	8
9	3	Housekeeping	Hours of Service	114,825	2	2,416,472	1,448,415	510	10,733	9
10	3	Housekeeping MCC	Square Feet)	17,705	2	174,133	110,156	16,119	158,534	10
11	1	Dietary	Patient Meals	275,875	2	3,265,302	1,747,865	81,138	960,363	11
12	22	Emp Ben/Cafeteria	Employee Meals	142,919	2	925,406	370,579	7,171	46,432	12
13	10	Medical Records	Time Spent	10,000	2	3,661,117	1,881,535	170	62,239	13
14	12	Social Service	Time Spent	107,716	2	725,704	443,577	17,792	119,868	14
15	43	Radiology	Revenue	31,117,657	2	9,346,298	3,079,530	81,304	24,420	15
16	43	Laboratory	Revenue	56,806,851	2	12,379,313	3,828,888	461,900	100,657	16
17	43	Nutritional Support	Revenue	532,936	2	455,473	207,737	38,108	32,569	17
18	43	EKG	Revenue	14,462,854	2	2,728,380	909,649	49,028	9,249	18
19	39	Drugs & IV Therapy	Revenue	20,220,805	2	9,344,196	1,925,469	801,253	370,265	19
20	39	Medical Supplies Sold	Revenue	2,374,495	2	3,621,142	573,591	45,789	69,829	20
21	10a	Respiratory Care	Revenue	12,009,717	2	3,246,615	1,757,891	241,518	65,290	21
22	10a	Physical Therapy	Revenue	12,886,385	2	5,154,910	2,721,965	974,120	389,675	22
23	10a	Occupational Therapy	Revenue	1,461,986	2	460,398	280,479	642,476	202,324	23
24	10a	Speech Therapy	Revenue	136,037	2	96,428	55,560	10,623	7,530	24
25	TOTALS					$ 98,017,871	$ 28,345,191		$ 3,994,315	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Capital Costs	See Attached	11,589,562	2	$ 11,589,562	$	244,210	$ 244,210	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,589,562	$		$ 244,210	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2				Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$ 8,826		$	$ (8,826)	$ 882,395	4
5			1966		144,150	581	30.89		(581)	144,150	5
6			1979		237,657	1,581	20.28	1,581		219,817	6
7			1980		2,695					2,695	7
8			1981		18,583					18,583	8
	Improvement Type**										
9	Electrical Upgrade			1996	25,549	1,358	18.79	1,358		10,196	9
10	Walking Track			1998	7,690	513	15	513		2,822	10
11	Roof Replacement			1998	68,383	6,839	10	6,839		37,610	11
12	Change in electrical power system			1998	5,479	365	15	365		2,007	12
13	7 1/2 ton A/C unit			1998	14,326	955	15	955		5,253	13
14	Air furnace			1998	15,226	1,015	15	1,015		5,583	14
15	5 ton air handler			1998	14,900	993	15	993		5,462	15
16	Electrical work-boiler rm,A/C unit, relamp,auto tr switch			1998	91,162	4,558	20	4,558		25,068	16
17	Air handling unit installed			1994	12,048	803	15	803		7,629	17
18	Repair parking lot			1994	83,569	2,783	10.85	2,783		65,786	18
19	Landscaping			1994	4,200	280	15	280		2,660	19
20	Flooring replaced in patient room			1993	56,883	3,793	15	3,793		39,818	20
21	Activity Therapy Renovation			1993	41,940	2,265	12.83	2,265		28,805	21
22	Condensing unit			1993	4,684	313	15	313		3,277	22
23	Air conditioners			1993	6,589	439	15	439		4,610	23
24	Upgrade lighting			1993	4,516	226	20	226		2,373	24
25	Renovate patient room & nurse station			1992	42,370	2,324	17.99	2,324		27,029	25
26	Renovate patient rooms-doors,wallcovering,bldg			1992	75,908	721	10.49	721		73,389	26
27	Roof top air conditioner			1992	4,342	290	15	290		3,330	27
28	Renovate business office			1991	35,387	1,818	18.5	1,818		25,512	28
29	Patient rooms-drywall,ceiling,paint			1991	39,835	2,424	14.55	2,424		33,280	29
30	Demolish back lounge			1991	752	50	15	50		625	30
31	Brickwork chimney			1991	5,225	349	15	349		4,352	31
32	Paint exterior tower			1991	1,185		5			1,185	32
33	ITE Panel			1991	995	50	20	50		625	33
34	Air conditioners			1991	6,580	439	15	439		5,481	34
35	Telephone wiring			1991	924		10			924	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Circuit breaker	1991	$ 1,011	$ 50	20	$ 50	$	$ 630	37
38	Cubicles & track	1990	9,899		5			9,899	38
39	Half glass door windows	1989	601	40	15	40		580	39
40	Roofing	1988	55,463		10			55,463	40
41	Air conditioner	1998	1,556		5			1,556	41
42	Air conditioner	1987	1,551		5			1,551	42
43	Remove bathroom showers	1987	17,966	462	15.56	462		16,345	43
44	Cooling units	1986	3,854		9			3,854	44
45	Cooling units	1985	5,644		10			5,644	45
46	Resurface road	1985	39,780		15			39,780	46
47	Guttering	1985	2,116		20			2,116	47
48	Metal door frames	1984	5,751	287	20	287		5,605	48
49	Water & sewer lines	1984	2,807	141	20	141		2,732	49
50	Sprinkle system	1978	27,578	552	25		(552)	27,578	50
51	Sprinkle system	1977	1,585		20			1,585	51
52	Cooling unit & heat detectors	1974	5,468					5,468	52
53	Air conditioners & beauty shop	1973	1,210					1,210	53
54	Heating & cooling eqquipment	1972	53,944					53,944	54
55	Smoke detector	1971	5,800					5,800	55
56	Land Improvements	1968	4,238		40	106	106	3,869	56
57	Vinyl flooring restrooms	1999	2,441	489	5	489		2,197	57
58	Reznor make up air unit	1999	15,432	1,543	10	1,543		6,944	58
59	Electrical work	1999	2,566	128	20	128		576	59
60	New door physical therapy	2000	3,735	249	15	249		872	60
61	Porch columns	2000	5,965	398	15	398		1,393	61
62	Repair walls	2001	2,080	139	15	139		347	62
63	Electrical work	2001	4,191	210	20	210		525	63
64	Electrical work	2001	16,778	839	20	839		2,097	64
65	Window replacement	2002	113,345	7,557	15	7,557		11,335	65
66	Storage addition	2002	253,195	16,879	15	16,879		25,322	66
67	Storage addition	2002	4,227	845	5	845		1,268	67
68	Storage addition	2002	1,259	629	1	629		1,259	68
69	Fire Alarm/Nurse Call Replacement	2002	4,473	299	15	299		448	69
70	TOTAL (lines 4 thru 69)		$ 2,633,636	$ 78,687		$ 68,834	$ (9,853)	$ 1,992,123	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,633,636	$ 78,687		$ 68,834	$ (9,853)	$ 1,992,123	1
2	Fire Alarm/Nurse Call Replacement	2002	350	117	3	117		175	2
3	Fire Alarm/Nurse Call Replacement	2002	1,001	200	5	200		300	3
4	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		7,219	4
5	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		49	5
6	Fire Alarm/Nurse Call Replacement	2002	61,775	3,088	20	3,088		4,631	6
7	Patient Wardrobe Units	2002	67,813	4,521	15	4,521		6,782	7
8	Patient Wardrobe Units	2002	5,824	582	10	582		873	8
9	Heating and Cooling Unit	2002	7,702	513	15	513		770	9
10	8" Faucts	2002	5,318	266	20	266		399	10
11	Window Replacment	2003	75	3	15	3		3	11
12	Storage Addition	2003	138	5	15	5		5	12
13	Fire Alarm/Nurse Call Replacement	2003	659	33	10	33		33	13
14	Window Replacment	2003	16,451	548	15	548		548	14
15	Patient Wardrobe Units	2003	16,789	420	20	420		420	15
16	Fire Alarm/Nurse Call Replacement	2003	19,745	494	20	494		494	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,885,891	$ 94,322		$ 84,469	$ (9,853)	$ 2,014,824	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 269,189	$ 22,480	$ 22,480	$		$ 196,315	71
72	Current Year Purchases	145,375	9,311	9,311		7.8	9,311	72
73	Fully Depreciated Assets	265,466					265,466	73
74								74
75	TOTALS	$ 680,030	$ 31,791	$ 31,791	$		$ 471,092	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	$ 49,174	$ 12,293	$ 12,293	$	4	$ 43,027	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$ 12,293	$ 12,293	$		$ 43,027	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,655,095	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 138,406	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,553	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,853)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,528,943	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 12,932 Description: see pg 24
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$ 171,250		$	$ 4,658		$ 175,908	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	260,945			5,635		266,580	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	76,083			293,652		369,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 508,278		$	$ 303,945		$ 812,223	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	775,968		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,603		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due third-party payers	(1,706)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 783,190	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,760,958		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	676,739		16
17	Accumulated Depreciation (book methods)	(2,469,578)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	152,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,160,408	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,943,598	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,622	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,098		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 245,720	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve for Self Insurance	382,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 382,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 627,720	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,315,878	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,943,598	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,185,477	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,185,477	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(326,158)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	390	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (325,768)	17
	B. Transfers (Itemize):		
18		456,169	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 456,169	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,315,878	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,954,372	1
2	Discounts and Allowances for all Levels	(1,744,258)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,210,114	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,627,219	6
7	Oxygen	241,518	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,868,737	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,491	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	801,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	461,900	19
20	Radiology and X-Ray	81,304	20
21	Other Medical Services	132,925	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,478,873	23
	D. Non-Operating Revenue		
24	Contributions	390	24
25	Interest and Other Investment Income***	44	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 434	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,558,158	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,075,682	31
32	Health Care	3,204,019	32
33	General Administration	925,062	33
	B. Capital Expense		
34	Ownership	138,406	34
	C. Ancillary Expense		
35	Special Cost Centers	481,627	35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,883,926	40
41	**Income before Income Taxes (line 30 minus line 40)****	(325,768)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (325,768)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	504	614	$ 20,579	$ 33.52	1
2	Assistant Director of Nursing	1,804	2,171	70,329	32.39	2
3	Registered Nurses	28,092	30,771	788,580	25.63	3
4	Licensed Practical Nurses	8,063	8,782	180,400	20.54	4
5	Nurse Aides & Orderlies	73,034	81,723	982,192	12.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,838	5,454	75,184	13.79	10
11	Social Service Workers	2,707	3,056	59,958	19.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,945	40,774	414,772	10.17	15
16	Dishwashers					16
17	Maintenance Workers	3,890	4,317	64,271	14.89	17
18	Housekeepers	8,888	10,443	110,156	10.55	18
19	Laundry					19
20	Administrator	1,277	1,557	52,496	33.72	20
21	Assistant Administrator	190	216	16,428	76.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,170	20,429	334,311	16.36	24
25	Vocational Instruction	7,636	8,781	171,250	19.50	25
26	Academic Instruction					26
27	Medical Director	93	107	13,272	124.04	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	106	119	1,509	12.68	31
32	Other Health Care(specify)	19,532	22,310	434,047	19.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	214,769	241,624	$ 3,789,734 *	$ 15.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	11	10,000	ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Physician Advisor	65	7,200	ln 10, col 3	46
47					47
48	Physician Reviewer		2,820	ln 10, col 3	48
49	TOTAL (lines 35 - 48)	76	$ 20,020		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,054	$ 50,435	Ln10 col 1	50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,575	64,860	Ln 10 col 1	52
53	TOTAL (lines 50 - 52)	4,629	$ 115,295		53

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ann Hagler	Admin.Assistant		$ 52,496
Joe Lanius	V.P.-Finance		7,008
Terry Walther	V.P. Rehab		9,420
Dr. William Sutherland	Medical Director		13,272
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 82,196

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
BKD,L.L.P.	Audit Fees	$ 4,100
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,100

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care	5,540
National Notary Assoc	64
American Assoc of Nurse	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,704

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
St Louis, Mo	77
In-State Travel	
Naperville, Il	346
	4
Seminar Expense	
IHCA - Medicaid Reimbursement	240
Home Pharmacy Services	155
IHCA - Restorative Nurse	160
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 982

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il. Health Care $5,540**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,933** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **46,432** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,108,416**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD,LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

XII. RENTAL COSTS

B 15	Item	Days	Price	Cost
	Wound Vac	104	62.80	6,531.20
	1st Step Plus Bed	18	16.50	297.00
	1st Step Select Bed	31	19.50	604.50
	VAD ATS System	78	70.50	5,499.00
	Equipment Rental			12,931.70